

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

Dr. Conrad

Reg. Dist. No. 305

## 1. PLACE OF DEATH

County Washington

City or town Breathedsville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Mos.

Hospital, institution, or street address where death occurred:  
Maryland State Penal Farm

How long in hospital or institution? 13 Mos.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Worcester

City or town Pocomoke City  
(If outside city or town limits, write RURAL and give nearest town)Street No. None  
(If rural, give LOCATION)

2.(a) If veteran, name war

None

## 3. (a) FULL NAME

Charles Bacon

## 3. (b) Social Security Number

None

4. Sex

M

5. Color or race

Colored

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) July 8, 1904

8. AGE: Years Months Days If less than one day

40

9

33

23

10

hrs.

min.

9. Birthplace Pocomoke City Worcester Co. Md.

(Town, county, and state)

10. Usual occupation Laborer.

11. Industry or business

12. Name Samuel Bacon

13. Birthplace Pocomoke City Md.

14. Maiden name No Record

15. Birthplace No Record

16. Informant Records of Md. State Penal Farm

Address Breathedsville Md.

17. Burial Date thereof June 5, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Pocomoke City Cemetery

Location Pocomoke City Soc. Co. Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown, Maryland

19. June 1, 1945 John H. Cook

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 31 1945 at 6p

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 1 1944 to May 31 1945

and that I last saw him alive on May 30 1945

Immediate cause of death

Ch. Myocarditis

DURATION

2 yrs.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert P. Conrad, M.D.

M. D. or other

Address Hagerstown Md Date signed 5-31-45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECORDED

JUN 5 1945

BUREAU V.E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Dr. Wells

05343

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 minutes

Hospital, institution, or street address where death occurred:

115 W. Church St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 137 South Prospect St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Harold Fendrick Bester

## 3. (b) Social Security Number

214-09-6450

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Jeanette C.6. (c) If alive, give age 39 years

7. Birth date of

deceased (mo., day, yr.) February 20 1905

8. AGE:

Years

Months

Days

If less than one day

40229

hrs.

min.

9. Birthplace Hagerstown, Wash. Co., Md. Pa.

(Town, county, and state)

10. Usual occupation Tax Collector11. Industry or business City of Hagerstown Md.12. Name Harry E. Bester13. Birthplace Hagerstown Md.14. Maiden name Miriam Fendrick15. Birthplace Mercersburg Pa.16. Informant Mrs. Jeannette C. BesterAddress Hagerstown Md.17. Burial Date thereof 5/21/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 21 19 45 Phyllis Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 1945 19 2:45 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

acute coronary occlusion

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of.....Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. 5/21/4523. SIGNATURE A. Robert Wells Date signed 5/21/45Address Hagerstown Md.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 23 1945

BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (107)

## CERTIFICATE OF DEATH

Beachley

05344

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 24 Hours  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 24 Hours

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 1209 Hamilton Blvd  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Emory Elbert Bradley

## 3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Carrie J.  
 6.(c) If alive, give age 67 years  
 7. Birth date of deceased (mo., day, yr.) September 27 1873  
 8. AGE: Years 71 Months 7 Days 8 If less than one day  
71 hrs. 7 min.

9. Birthplace Vienna Dorchester Co Md  
 (Town, county, and state)  
 10. Usual occupation W.M.R.R. Clerk  
 11. Industry or business Retired  
 12. Name William S. Bradley  
 13. Birthplace Dorchester Md.  
 14. Maiden name Emily Hopkins  
 15. Birthplace Dorchester Md

16. Informant Mrs. Carrie J. Bradley  
 Address Hagerstown Md.  
 17. Burial Date thereof 5/8/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Washington Cemetery  
 Location Hurlock Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. May 7 1945 Charles Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 1945 at 1:30 P

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 45 to May 5 45  
 and that I last saw him alive on May 5 45  
 Immediate cause of death Broncho Pneumonia

DURATION 2 Days  
 Due to .....  
 Due to .....  
 Other conditions Stomach & Perforia 2 Days  
 (Include pregnancy within 3 months of death)

Major findings of operations .....  
 Date of op. ....

Autopsy results .....  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide ..... Date of .....  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work?

23. SIGNATURE J. V. Beachley M. D. or Hagerstown, Md  
 Address Hagerstown, Md Date signed 5/11/45

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

RECEIVED

MAY 9 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

FILM No. G 95 JUN 16 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 330

## CERTIFICATE OF DEATH

05345

Reg. Dist. No. 302

1. PLACE OF DEATH: Washington  
County.....  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 50 years  
Hospital, institution, or street address where death occurred:  
.....  
How long in hospital or institution? 4 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State..... Maryland..... County..... Washington.....  
City or town..... Hagerstown.....  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 423 Jonathan.....  
(If rural, give LOCATION)  
No

### 3. (a) FULL NAME

Samuel Lloyd Branch

3. (b) Social Security Number  
No

4. Sex Male 5. Color or race Colored 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife.....  
6. (c) If alive, give age..... years  
7. Birth date of deceased (mo., day, yr.) November 17, 1880.  
8. AGE: Years Months Days If less than one day  
65- 64 6 12 hrs. min.

9. Birthplace Franklyn County Penna.  
(Town, county, and state)  
10. Usual occupation Real estate dealer  
11. Industry or business

FATHER  
12. Name Samuel Branch  
13. Birthplace Richmond, Va.  
MOTHER  
14. Maiden name Susan Alford  
15. Birthplace Pennsylvania  
16. Informant George Branch  
Address Hagerstown

17. Burial Date thereof May 31, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory Green Hill  
Location Greencastle, Pa.  
18. Funeral director Fred W. Kraiss.  
Address Hagerstown

19. May 31, 45 Hagerstown, Pa.  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945 at A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/25 1945 to 5/28 1945  
and that I last saw him alive on 5/27 1945

Immediate cause of death Cerebral Hemorrhage 4 days

Due to arterio-sclerosis (?)

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

131 W. WASHINGTON ST.  
HAGERSTOWN, MD.

23. SIGNATURE Victor D. Miller M. D. or other

DR. VICTOR D. MILLER.

Address 131 W. WASHINGTON ST. Date signed 5/28/1945

RECEIVED

JUN 2 1945

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Rural Leffersburg  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 2 months  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Dusan Elizabeth Brandenburg

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed

6. (b) Name of husband or wife Tracey Brandenburg  
6. (c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) March 21, 1860

8. AGE: Years 85 Months 1 Days 19 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace NW Myerhill, Frederick Co. Md.  
(Town, county, and state)

10. Usual occupation Retired

11. Industry or business Domestic

12. Name Henry Garen

13. Birthplace Md.

14. Maiden name Malinda Cline

15. Birthplace Md.

16. Informant Mrs John C. Palmer

Address Leffersburg, Md

17. Funeral Date thereof May 13, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Mark's Lutheran

Location Wolfpsrill, Md. P.O. Smithsburg

18. Funeral director J. Thos. Bittler & Son

Address Myersville, Md.

19. May 12, 1945 Charles H. Bowers  
(Date rec'd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Frederick  
City or town Rural Wolfpsrill P.O. Smithsburg  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. \_\_\_\_\_  
(If rural, give LOCATION)  
2. (a) If veteran, name war \_\_\_\_\_

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 18 1945 at 11 P M

21. CERTIFY that death occurred on the date above stated; that I attended deceased from April 20 1945 to May 10 1945

and that I last saw him alive on May 10 1945

Immediate cause of death Coronary Atherosclerosis DURATION 2 days

Due to Coronary Atherosclerosis 3 yrs

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Anteopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

\_\_\_\_\_ (City or town) (County) (State)

\_\_\_\_\_ (City or town) (County) (State)

\_\_\_\_\_ (City or town) (County) (State)

23. SIGNATURE H. G. H. Miller M. D. or other \_\_\_\_\_

Address Smithsburg Date signed 5/11/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 15 1945  
BUREAU V.A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05347

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Sp. Md.  
 City or town Smithsburg and  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 1 week  
 Hospital, institution, or street address where death occurred:  
Smithsboro Hospital  
 How long in hospital or institution? 1 week

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Smithsburg and  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Washington Co. Hospital  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war none

## 3. (a) FULL NAME

Mrs. Laura Burkhardt

## 3. (b) Social Security Number

none

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white widowed

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 9/1/18708. AGE: Years Months Days If less than one day  
74 8 3 - hrs. - min.6. Birthplace Smithsburg and  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Joseph. Kinder13. Birthplace Germany14. Maiden name Catherine Hartman15. Birthplace Van Smithsburg16. Informant Mrs. Catherine. HouseAddress Smithsburg and17. (Burial, cremation, or removal of which?) Date thereof 5-14-1945  
(month) (day) (year)Cemetery or crematory SmithsburgLocation Smithsburg road18. Funeral director Geo. A. HooverAddress Smithsburg and19. (Date rec'd by registrar) May 12 1945 Registrar J. C. H. H. H. H.

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 at 4:30 P M21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Apr 27 1945 to May 11 1945 and that I last saw her alive on May 11 1945Immediate cause of death Peritonitis

## DURATION

Due to abd. sectionDue to 72 large ovariesOther conditions cent.

(Include pregnancy within 3 months of death)

Major findings of operations Ovarian cyst - postmenstrual  
feeling the sub's old Date of op. May 1-45Autopsy results Office peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm. L. L. L. L. M. D. or otherAddress Hagerstown, Md Date signed 5/11-45

MAILED AND SENT DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

MAY 15 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Dr. Binkley T

05348

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 4 Years

Hospital, institution, or street address where death occurred:

911 Guilford AveHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 911 Guilford Ave

(If rural, give LOCATION)

None

2. (a) If veteran, name war.....

## 3. (a) FULL NAME

Walter Lee Carson

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Hannah6. (c) If alive, give age 73 years

7. Birth date of

deceased (mo., day, yr.)

April 20 1870

8. AGE:

Years

75

Months

0

Days

18

If less than one day

.....hrs. ....min.

9. Birthplace

Hagerstown Wash. Co. Md.

(Town, county, and state)

10. Usual occupation

Mail Carrier

11. Industry or business

Retired

FATHER

12. Name

John T. Carson

13. Birthplace

Hagerstown Md.

MOTHER

14. Maiden name

Mary V. Dundore

15. Birthplace

Libertytown Md.

16. Informant

R. Bruce Carson

Address

Hagerstown Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

5/5/45

(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19.

May 4, 1945

(Date rec'd by registrar)

W. H. Bowers

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 3 1945 19... at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 3 1945 to May 3 1945and that I last saw him alive on May 3, 1945

Immediate cause of death

Coronary Thrombosis

DURATION

1 hr

Due to.....

Due to.....

Other conditions

Arterio Sclerosis10 yrs

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury .....

Injured at work?

23. SIGNATURE

W. H. Binkley

M. D. or other

Address

Hagerstown MdDate signed 5/4/45

RECEIVED

MAY 7 1945

BUREAU OF

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (82)

## CERTIFICATE OF DEATH

05342 302  
Reg. Dist. No. ....

### 1. PLACE OF DEATH:

County Washington  
City or town Samuels Manor  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 1 yr 2 mo  
Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Beverly Mac Cavender

### 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife no

7. Birth date of deceased (mo., day, yr.) March 26 1944 6. (c) If alive, give age — years

8. AGE: Years 1 Months 1 Days 24 If less than one day — hrs. — min.

8. Birthplace Daguerstown, Md.  
(Town, county, and state)

10. Usual occupation none

11. Industry or business none

12. Name Charles Watson Cavender

13. Birthplace State of Pa.

14. Maiden name Velma Louise Brim

15. Birthplace Samuels Manor, Md.

16. Informant Mrs. Velma C. Brim

Address Samuels Manor, Md.

17. Burial May 21-45

(Burial, cremation, or removal. Which?) Date thereof (month) (day) (year)

Cemetery or crematory Cemetery

Location Samuels Manor, Md.

18. Funeral director H. Backus

Address Bolivar, W. Va.

19. May 20 19 45 Donald H. Castle

(Date recd by registrar) Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Samuels Manor, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. ....  
(If rural, give LOCATION)

2. (a) If veteran, name war

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 19 19 45 at 8:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 19 19 45 to May 19 19 45  
and that I last saw him alive on May 19 19 45

Immediate cause of death

Acute fulminating meningitis  
Due to gas  
Capitulum agent not identified  
Acute meningitis type not determined  
Other conditions ever

DURATION

12 hours

(Include pregnancy within 8 months of death)

Major findings of operations none

Date of op. ....

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Spauldy M.D.

Address Sharpsbury, Md. M. D. or other

Date signed 5/19/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
MAY 22 1945  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1310)

## CERTIFICATE OF DEATH

Reg. Dist. No. 305

### 1. PLACE OF DEATH

County Washington  
City or town Breathedsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? Life  
Hospital, institution, or street address where death occurred:  
Boonsboro R.I.  
How long in hospital or institution? at Home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Breathedsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Boonsboro Md. R. I.  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

### 3. (a) FULL NAME

Clorinda Chaney

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Single

6.(b) Name of husband or wife Single

7. Birth date of deceased (mo., day, yr.) November 3 - 1865

8. AGE: Years 79 Months 6 Days 3 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Breathedsville Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation None

11. Industry or business at Home

12. Name Dr. Joseph P. Chaney

13. Birthplace Breathedsville Wash. Co. Md.

14. Maiden name Maria Jan Lear

15. Birthplace no Record

16. Informant Mr. Eastburn Chaney

Address Boonsboro Md. R. I.

17. Burial Date thereof May 18, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Marks Cemetery

Location Lappans Md.

18. Funeral director Wm. D. Bax & Sons

Address Boonsboro Md.

19. May 18, 1945 John H. Bax  
(Date filed by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH 5/16 - 19 45 at 10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 1, 1944 to May 16, 1945

and that I last saw him alive on May 15, 1945

Immediate cause of death Chronic arthritis

Chronic hepatitis

Due to Chronic subacute

arthritis & diabetes

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. Victor D. Miller

DR. VICTOR D. MILLER, M. D. or other \_\_\_\_\_

Address 181 W. WASHINGTON ST. Date signed 5/16 1945

DAYSTOWN, MD.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Victor D. Miller

RECEIVED

MAY 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 191-2

## CERTIFICATE OF DEATH

Reg. Dist. No. 0535302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 30 yrs  
 Hospital, institution, or street address where death occurred:  
342 N. Jonathan  
 How long in hospital or institution? \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 342 N. Jonathan  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Burnside Clark

## 3. (b) Social Security Number

4. Sex Male 5. Color or race Col 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Mrs. Annie Clark  
 7. Birth date of deceased (mo., day, yr.) May 5 1870 8. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 75 Months \_\_\_\_\_ Days \_\_\_\_\_ If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Downsville Md  
 (Town, county, and state)

10. Usual occupation Salvager

## 11. Industry or business

12. Name Burnside Clark  
 13. Birthplace Downsville Md

14. Maiden name \_\_\_\_\_  
 15. Birthplace \_\_\_\_\_

16. Informant Edith May Clark  
 Address 342 N. Jonathan St

17. Burial Date thereof May 31, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown

18. Funeral director William H. Droney  
 Address 291 Frederick St

19. June 5, 1945 Registrar  
 (Date reported by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 - 1945 at 10 a M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 1945, to May 1945, and that I last saw him alive on May 1945

Immediate cause of death Chronic Endocarditis  
Rheumatic Nephritis  
arterio-sclerosis  
 Due to \_\_\_\_\_  
 Due to \_\_\_\_\_

## DURATION

6-7 years

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

Victor D. Miller

23. SIGNATURE VICTOR D. MILLER M. D. or other

Address 131 W. WASHINGTON ST. Date signed 5/30/1945

UNITED STATES DEPARTMENT OF JUSTICE

OFFICE OF THE ATTORNEY GENERAL

WASHINGTON, D. C. 20530

RECEIVED  
JUN 7 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 307

## 1. PLACE OF DEATH:

County WashingtonCity or town Rural Capland  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Keedysville, R. F. D.  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Samuel Clark

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife \_\_\_\_\_

8. (c) If alive, give age \_\_\_\_\_ years

## 7. Birth date of

deceased (mo., day, yr.)

Dec. 17, 1928

## 8. AGE:

Years 16Months 5Days 8

If less than one day

\_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Mt. Briar-Wash.-Maryland  
(Town, county, and state)10. Usual occupation Laborer

## 11. Industry or business

12. Name Unknown

13. Birthplace

14. Maiden name Dora Clark15. Birthplace Mt. Briar, Maryland16. Informant Dora ClarkAddress Mt. Briar - Keedysville R. F. D.17. Burial Date thereof 5-29-1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Mt. PleasantLocation Near Keedysville, Md.18. Funeral director R. L. EarnshawAddress Keedysville, Md.19. May 28 1945 Mrs. Katherine Dargatzis  
(Date recd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 25 1945 at 10 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_\_, and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_\_.

## Immediate cause of death

Open fracture of skullDue to Hemorrhage and shockDue to \_\_\_\_\_  
Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. \_\_\_\_\_

Autopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 5/25/45Where did injury occur? Caplan d Washington Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) HighwayMeans of injury Fell out of truck Injured at work? yesDEPUTY MEDICAL EXAM. S. Robert Wells WASH. CO., MD.

23. SIGNATURE \_\_\_\_\_ M. D. or other

Address Hagerstown, Md. Date signed 5/26/45

RECEIVED  
MAY 31 1945  
BUREAU

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 05353 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown, Md.  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
Washington Co. Hospital  
How long in hospital or institution? 14 Days

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Rural Hancock  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Route 40 West  
(If rural, give LOCATION)  
2.(a) If veteran, name war

### 3. (a) FULL NAME

Charles Rush Cook

### 3. (b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single  
6.(b) Name of husband or wife  
7. Birth date of deceased (mo., day, yr.) May 2 1945 6.(c) If alive, give age 10 years  
8. AGE: Years 78 Months 0 Days 0 If less than one day 0 hrs. 0 min.

9. Birthplace Chambersburg- Franklin - Pa.  
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER 12. Name Not known  
13. Birthplace

MOTHER 14. Maiden name Not known  
15. Birthplace

16. Informant Chas Remington  
Address Hancock R.F.D.

17. Burial Date thereof May 12 45  
(Burial, cremation, or removal. Which?) (month) (day) (year)  
Cemetery or crematory S. Peter's Catholic  
Location Hancock, Md.

18. Funeral director Snyder-Rowland Funeral Home  
Address Hancock, Md.

19. May 12 45 (Date rec'd by registrar) Registrar Chas H Bowers

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 9th 1945 19 45 at 11:50 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 2 1945 to May 9 1945  
and that I last saw him alive on May 9 1945

Immediate cause of death arterio sclerosis DURATION 10 yrs

Due to

Other conditions chr nephritis Hypertension ?  
(Include pregnancy within 3 months of death) ?

Major findings of operations

Autopsy results  
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
Accident, suicide, or homicide Date of  
Where did injury occur? (City or town) (County) (State)  
Injured at home, farm, industry, public place (where?)  
Means of injury Injured at work?

23. SIGNATURE Chas H Bowers M. D. or other  
Address Hagerstown Md Date signed 5/11/45

MARGIN RESERVED FOR BINDING

VS 415

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED IN DEPT. OF JUSTICE

STATE OF NEW YORK

RECEIVED  
MAY 15 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (162-E)

## CERTIFICATE OF DEATH

Reg. Dist. No.

05354

301

## 1. PLACE OF DEATH:

County WashingtonCity or town Williamsport  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 83 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Williamsport, Md.  
(If outside city or town limits, write RURAL and give nearest town)Street No. Potomac St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Annie McCardell Curfman

## 3. (b) Social Security Number

None4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widowed6. (b) Name of husband or wife Charles E Curfman  
deceased 6. (c) If alive, give age ..... years7. Birth date of deceased (mo., day, yr.) June 13 18618. AGE: Years 83 Months 10 Days 19 If less than one day ..... hrs. .... min.9. Birthplace Williamsport, Maryland  
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Charles McCardell  
13. Birthplace Williamsport, Md.14. Maiden name Katherine Wolfe  
15. Birthplace Maryland16. Informant Maria Curfman (daughter)Address Williamsport, Maryland17. Burial Burial Date thereof May 4 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Riverview CemeteryLocation Williamsport, Maryland18. Funeral director Edith V LeafAddress #7 Church St. Williamsport, Md.19. May 4 1945 Registrar Mrs E L M. Williamsport Md  
(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 2 1945, at 12:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 1 1945, to May 2 1945 and that I last saw him alive on May 2 1945Immediate cause of death I do not know any definite disease. "Senile" Condition alone.

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE [Signature] M. D. or other 5/4/45  
Address Williamsport Md Date signed

RECEIVED  
MAY 7 1945  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (87d)

## CERTIFICATE OF DEATH

Dr. Hornbaker

05355

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 10 Minutes  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution? 10 Minutes

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 501 South Potomac St.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war None

## 3. (a) FULL NAME

Mrs Luella Frances Early  
 4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

## 3. (b) Social Security Number

None

## 8. (b) Name of husband or wife

William  
 6.(c) If alive, give age 37 years  
 7. Birth date of deceased (mo., day, yr.) December 19 1908

8. AGE: Years 36 Months 4 Days 12 If less than one day  
hrs. min.

9. Birthplace Mt. Tabor Wash. Co. Md.  
 (Town, county, and state)

## 10. Usual occupation

Housewife

## 11. Industry or business

Own Home

12. Name Foster J. Long

13. Birthplace Middletown Md.

14. Maiden name Minnie Longnecker

15. Birthplace Monroe Md.

16. Informant William Early

Address Hagerstown Md.

17. Burial Date thereof 5/4/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown Md.

18. Funeral director Andrew K. Coffman

Address Hagerstown Md.

19. May 4 19 45 6:30 p.m.  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 45 at 8:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5/12/42 19 45 to 5/1/45 19 45  
 and that I last saw h. er alive on 5/1/45 19 45

Immediate cause of death Pulmonary Embolism DURATION 1 1/2 hours

Due to Chronic Heart Disease 18 years

Due to Multiple sclerosis about 4 years  
 Other conditions Multiple sclerosis  
 (Include pregnancy within 3 months of death)

Major findings of operations — Date of op. —

Autopsy results —  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide — Date of —

Where did injury occur? — (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —

Means of injury — Injured at work? —

23. SIGNATURE John Hornbaker, M.D. M. D. or other

Address 154 W. Wash. St. Date signed 5/2/45  
Hagerstown, Md.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 7 1945

BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

05356

<b>1. PLACE OF DEATH:</b> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>4 years</u> Hospital, institution, or street address where death occurred: <u>525 N. Locust St.</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) <u>Maryland</u> State <u>Washington</u> County City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>525 N. Locust St.</u> (If rural, give LOCATION) <u>Spanish American</u> 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Adam A Erdman</u>				<b>3. (b) Social Security Number</b> <u>214-05-7868</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Married</u>			
<b>6. (b) Name of husband or wife</b> <u>Matilda S. Erdman</u>				<b>6. (c) If alive, give age</b> <u>61</u> years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>April 30 1879</u>							
<b>8. AGE:</b> Years <u>66</u>		Months <u>0</u>		Days <u>7</u>		It less than one day .....hrs. ....min.	
<b>9. Birthplace</b> <u>Eisenack Germany</u> (Town, county, and state)							
<b>10. Usual occupation</b> <u>Retired</u>							
<b>11. Industry or business</b> <u>Collector</u>							
<b>12. Name</b> <u>Unknown</u>							
<b>13. Birthplace</b>							
<b>14. Maiden name</b> <u>II</u>							
<b>15. Birthplace</b> <u>II</u>							
<b>16. Informant</b> <u>Mr. Robert E. Erdman</u> Address <u>Cum</u> <u>berland Md.</u>							
<b>17. Burial</b> <u>May. 10 1945</u> (Burial, cremation, or removal. Which?) <u>St. Lukes</u> Cemetery or <u>Cumberland Md.</u> Location <u>Scott F. Minnich &amp; Son</u> <b>18. Funeral director</b> <u>Hagerstown Md.</u> Address							
<b>19. May 8 45</b> (Date rec'd by registrar) Registrar							
<b>MEDICAL CERTIFICATION</b> <b>20. DATE OF DEATH</b> <u>May 7 1945</u> at <u>4:45 p.m.</u> <b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>5/7 45</u> <u>5/7 45</u> and that I last saw him alive on <u>5/7 45</u> Immediate cause of death <u>Cornary Arteriosclerosis</u> <u>arterio-sclerosis</u> Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically. <b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of Injury..... Injured at work?..... <b>23. SIGNATURE</b> <u>V. H. Dueller</u> M. D. or other Address..... Date signed <u>5/8 1945</u>							

RECEIVED  
MAY 10 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 05357 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 50 years  
 Hospital, institution, or street address where death occurred:  
 21 South Potomac Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 21 South Potomac Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Lela May Feigley

## 3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 6. (b) Name of husband or wife Harry F. Feigley, Sr.  
 6. (c) If alive, give age 73 years  
 7. Birth date of deceased (mo., day, yr.) August 22, 1871  
 8. AGE: Years 73 Months 8 Days 16 If less than one day  
 hrs. min.

9. Birthplace Greenscastle, Franklin Co. Pa.  
 (Town, county, and state)

10. Usual occupation Housewife

## 11. Industry or business

12. Name George N. Frederick  
 13. Birthplace Chambersburg, Pa.  
 14. Maiden name Mary E. Reiff  
 15. Birthplace Hagerstown, Maryland

16. Informant Harry F. Feigley  
 Address Hagerstown, Maryland

17. Burial Date thereof 5-11-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. May 11 45 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5-9-45 19... at... M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5-1-45 19... to 5-9-45 19...

and that I last saw h... alive on... 19...

Immediate cause of death Congestive Heart Failure DURATION 4 mos.

Due to

Due to

Other condition Hypertensive Heart Disease

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE St. Louis, Mo. M. D. or other

Address Date signed

RECEIVED

MAY 14 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr Wishard

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (928)

## CERTIFICATE OF DEATH

Reg. Dist. No. 05358 306

## 1. PLACE OF DEATH:

County Washington  
 City or town Blue Ridge Summit  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 75 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants, give residence of mother)  
 State Maryland County Washington  
 City or town Blue Ridge Summit  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

Susan Elizabeth Flohr

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female W Married

6. (b) Name of husband or wife Daniel C Flohr

7. Birth date of deceased (mo., day, yr.) 6. (c) If alive, give age 79 years  
March 29 18708. AGE: Years Months Days If less than one day  
75 1 16 hrs. min.9. Birthplace Fountaindale Penna  
(Town, county, and state)

10. Usual occupation House wife

## 11. Industry or business

12. Name John McClain

13. Birthplace Adams Co Pa

14. Maiden name Rebecca Cline

15. Birthplace Adams Co Pa

16. Informant Daniel C Flohr

Address Blue Ridge Summit Md

17. Burial, cremation, or removal, Which? Date thereof 5 17 1945  
(month) (day) (year)

Cemetery or crematory Bethel Cemetery

Location Near Cascade Md

18. Funeral director Walter Y Grove

Address Waynesboro Penna

19. May 17 1945 Geo H. Angerson  
(Date rec'd by registrar) (month) (day) (year) Registrar

## MEDICAL CERTIFICATION

2D. DATE OF DEATH May 15 1945 at 4 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 19 to May 15 1945  
and that I last saw him alive on May 14 1945

Immediate cause of death Central Hemorrhage

Due to Generalized arteriosclerosis

Due to atherosclerosis

Other conditions Chronic valvular heart disease - double mitral  
(Include pregnancy within 8 months of death)

## Major findings of operations

Date of op.

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Walter H. Angerson M.D.  
M. D. or otherAddress Waynesboro Pa.  
15-2 W Main St. Date signed 5/15/45DURATION  
5/13/45  
2 days

RECEIVED  
MAY 22 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (23-2)

## CERTIFICATE OF DEATH

05359 303  
Reg. Dist. No.

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Rural Clear Spring, Md.  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 82 years  
 Hospital, institution, or street address where death occurred: Near Indian Springs Dist. Route 40  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Clear Spring, Md. Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... Indian Springs Dist.  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

John E. Forsyth

## 3. (b) Social Security Number

None

4. Sex <u>Male</u>	5. Color or race <u>White</u>	6. (a) Single, married, widowed, or divorced <u>Married</u>
-----------------------	----------------------------------	--

## MEDICAL CERTIFICATION

6. (b) Name of husband or wife... Amanda Elizabeth Forsyth

7. Birth date of deceased (mo., day, yr.) May 12, 1862  
 6. (c) If alive, give age... years

8. AGE: Years <u>82</u>	Months <u>11</u>	Days <u>23</u>	If less than one day hrs. min.
----------------------------	---------------------	-------------------	-----------------------------------

9. Birthplace... Washington County, Md.  
(Town, county, and state)10. Usual occupation... Carpenter

11. Industry or business

12. Name... Henry A. Forsyth13. Birthplace... Wash. Co., Md.14. Maiden name... Mary A. Bridendolph15. Birthplace... Wash. Co., Md.16. Informant... Mrs. Amanda ForsythAddress... Clear Spring, Md. R F D17. Burial... Date thereof May 7, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... St. Paul's CemeteryLocation... Route 40 near Clearspring, Md.18. Funeral director... Fred W. Kraiss.Address... Hagerstown19. May 6 19 45 Joseph W. Murray  
(Date rec'd by registrar) Registrar20. DATE OF DEATH... May 4, 1945 4:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 30, 1945 to May 4, 1945  
 and that I last saw him alive on May 3, 1945  
 Immediate cause of death...

<u>Cerebral Hemorrhage</u> Due to... <u>Arterio Sclerosis</u> Due to... Other conditions... (Include pregnancy within 3 months of death) Major findings of operations... Date of op... Autopsy results... PHYSICIAN: Please indicate the cause to which death should be charged statistically.	DURATION <u>5 days</u> <u>5 yrs.</u>
---	--

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... David P. Brewer M.D.Address... Clear Spring Md Date signed 5/5/45

UNITED STATES DEPARTMENT OF JUSTICE

STANDARD FORM NO. 64

RECEIVED

MAY 8 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 44 years  
 Hospital, institution, or street address where death occurred:  
50 West Hill Crest Road  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 50 West Hill Crest Road  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

J. Morris Guider

## 3. (b) Social Security Number

214-09-2746

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
 B. (b) Name of husband or wife Ruth (Conner) Guider  
 6. (c) If alive, give age 46 years  
 7. Birth date of deceased (mo., day, yr.) February 21, 1885  
 8. AGE: Years 60 Months 3 Days 5 If less than one day  
 hrs. min.

9. Birthplace Baltimore, Maryland  
 (Town, county, and state)  
 10. Usual occupation Produce Dealer  
 11. Industry or business State Distributor  
 12. Name Charles Guider  
 13. Birthplace Baltimore, Maryland  
 14. Maiden name Catherine Wheat  
 15. Birthplace Baltimore, Maryland  
 16. Informant Mrs. J. Morris Guider  
 Address Hagerstown, Maryland

17. Burial Date thereof 5-28-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Mausoleum  
 Location Hagerstown, Maryland  
 18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. May 28, 45 Registrar  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 26, 1945 19... at 8:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May - 1944, to May 26, 1945  
 and that I last saw him alive on May 19, 1945

Immediate cause of death  
Carcinoma of rectum  
 DURATION 1 Year  
 Due to  
 Due to  
 Other conditions  
 (Include pregnancy within 8 months of death)

Major findings of operations  
 Date of op.  
 Autopsy results  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide Date of  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE H. Campbell M. D. or other  
 Address 1457 1/2 Washington St. Date signed May 26, 45

RECEIVED

MAY 31 1945

BUREAU V.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 05361 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County AlleghenyCity or town Cumberland  
(If outside city or town limits, write RURAL and give nearest town)Street No. 413 N. Center Street  
(If rural, give LOCATION)2.(a) If veteran, name war ☒

## 3. (a) FULL NAME

Walter James Hager

## 3. (b) Social Security Number

217-10-1403

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

1905

6. (c) If alive, give age ..... years

8. AGE:

Years 40

Months

Days

If less than one day

..... hrs. .... min.

9. Birthplace

Unknown

(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

Walter Hager

13. Birthplace

Unknown

14. Maiden name

Unknown

15. Birthplace

Unknown

16. Informant

From cards found on body

Address

17.

(Burial, cremation, or removal. Which?)

BurialDate thereof May 24, 1945  
(month) (day) (year)

Cemetery or crematory

Bellevue Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19.

(Date rec'd by registrar)

19.

45Clash H. Bowers  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945 2:25 A.M. at M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to ..... 19.....

and that I last saw him ..... alive on ..... 19.....

Immediate cause of death

DURATION

Chr. bronchial asthma

Due to

chr. myocarditis

Due to

Emphysemata lungs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no

Date of op.

Autopsy results

as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

No

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Robert Wells  
Hagerstown, Md.

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. on

Address

Date signed

May 25/45

RECEIVED

MAY 29 1945

BUREAU V.C.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Wells

05362

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown R # 1  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 Years

Hospital, institution, or street address where death occurred:

near ChewsvilleHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown R # 1  
(If outside city or town limits, write RURAL and give nearest town)Street No. near Chewsville

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

Charles Thomas Hann

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Anne6. (c) If alive, give age 65 years

7. Birth date of

deceased (mo., day, yr.) January 9 1878

8. AGE:

Years

67

Months

3

Days

24

If less than one day

hrs.

min.

9. Birthplace Hampstead Carroll Co Md

(Town, county, and state)

10. Usual occupation Passenger Conductor11. Industry or business W.M.R.R.12. Name James Hann13. Birthplace Hampstead Md.14. Maiden name Keniah Gayble15. Birthplace Hampstead, Md.16. Informant Russell J. HannAddress Hagerstown Md.17. Burial Date thereof 5/8/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.16. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 5. 45 Charles Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 5 1945 19 at 3 A. M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

19 to 19

and that I last saw h. alive on 19

Immediate cause of death

acute coronary occlusion 2hrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. Robert Wells DEPUTY MEDICAL EXAM.

WASH. CO., MD.

Address Hagerstown, Md. Date signed 5/5/45

RECEIVED  
MAY 8 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1862

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
6 weeks  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
62 Elizabeth Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 62 Elizabeth Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Frank F. Hanson

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Widower  
 6. (b) Name of husband or wife Annie R. Hanson  
 7. Birth date of deceased (mo., day, yr.) November 15, 1865 6. (c) If alive, give age \_\_\_\_\_ years  
 8. AGE: Years 79 Months 6 Days 4 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Dam #4, Wash. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Laborer

## 11. Industry or business

FATHER 12. Name George Hanson  
 13. Birthplace Sharpsburg, Maryland  
 MOTHER 14. Maiden name Rosie --  
 15. Birthplace Sharpsburg, Maryland

16. Informant William Hanson  
 Address Hagerstown, Maryland

17. Burial 5-22-45  
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Riverview Cemetery  
 Location Williamsport, Maryland

18. Funeral director C. M. Suter & Sons  
 Address Hagerstown, Maryland

19. May 21, 1945  
 (Date rec'd by registrar) Registrar Charles H. Bowers

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 19, 1945, at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1, 1945, to May 19, 1945  
 and that I last saw him alive on May 19, 1945

Immediate cause of death Chronic Brights Dis. DURATION 1 yr

Due to \_\_\_\_\_

Other conditions Contusion right hip 1 week  
Due to fall  
 (Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE David P. Brewer M. D. or other  
 Address Clear Spring Md. Date signed May 21, 1945

RECEIVED

MAY 23 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 5 yrs  
 Hospital, institution, or street address where death occurred:  
2 Court St  
 How long in hospital or institution? .....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 2 Court St  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war no

## 3. (a) FULL NAME

Edward Jackson

## 3. (b) Social Security Number

214-09-8372

## 4. Sex

Male

## 5. Color or race

Col

## 6. (a) Single, married, widowed, or divorced

Single

## 6. (b) Name of husband or wife

.....

## 7. Birth date of deceased (mo., day, yr.)

Feb 24 1895

## 8. AGE:

Years 50 Months 0 Days 0 If less than one day  
 .... hrs. .... min.

## 9. Birthplace

Front Royal Va  
(Town, county, and state)

## 10. Usual occupation

Salesman

## 11. Industry or business

John Jackson

## 12. Name

John Jackson

## 13. Birthplace

Billie Gordon

## 14. Maiden name

Billie Gordon

## 15. Birthplace

Harry Jackson

## 16. Informant

Martinsburg W. P. A. R.

## 17. Burial

County Home

## 18. Funeral director

William H. Downey

## 19. Address

291 Frederick St

## 20. Date

May 11 45

## 21. Date rec'd by registrar

May 11 45

## 22. Registrar

Charles Howard

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 8 1945 at 1:45 P.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19..... to..... 19.....

and that I last saw him..... alive on..... 19.....

## Immediate cause of death

Coronary arteriosclerosis

Due to.....

acute coronary

Due to.....

occlusion

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... NoAutopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... Robert S. Wells DEPUTY MEDICAL EXAMINERAddress..... Hagerstown, Md. WASH. CO., MD.Date signed..... 5/10/45

REC

MAY 14 1945

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (167)

## CERTIFICATE OF DEATH

Dr. Wells

05365

Reg. Dist. No. 305

## 1. PLACE OF DEATH:

County WashingtonCity or town Breathedsville  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 2 WeeksHospital, institution, or street address where death occurred:  
Maryland State Penal FarmHow long in hospital or institution? 2 Weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County BaltimoreCity or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)Street No. 11 North Caroline St.  
(If rural, give LOCATION)2.(a) If veteran, name war None ✓

## 3.(a) FULL NAME

William D. Johnson

## 3.(b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Male Colored Single

6.(b) Name of husband or wife

6.(c) If alive, give age — years7. Birth date of deceased (mo., day, yr.) December 24 19388. AGE: Years Months Days If less than one day  
16 4 17 — hrs. — min.9. Birthplace Baltimore Baltimore Co. Md.  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business

12. Name William Johnson13. Birthplace Baltimore Md14. Maiden name Alice Johnson15. Birthplace Baltimore Md.16. Informant Md/ State Penal Farm RecordsAddress Breathedsville Md.Burial17. (Burial, cremation, or removal. Which?) Date thereof May 16-1945  
(month) (day) (year)Cemetery or crematory Mt. Calvary CemeteryLocation Nr. Baltimore, ANN Arundle Co., Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 12 19 45 John H. East  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

P

20. DATE OF DEATH May 11 1945 19 —, at 6.03 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 —, to 19 —and that I last saw him — alive on 19 —

Immediate cause of death

## DURATION

Hemorrhage, severed externalDue to and internal jugular vein

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations NoneDate of op. NoneAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Homicide Date of 5/11/45Where did injury occur? Breathedsville Wash. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Penal FarmMeans of injury Stab wound Injured at work? No

DEPUTY MEDICAL EXAM.

23. SIGNATURE S. R. Wells WASH. CO., MD.Address Hagerstown, Md. M. D. —  
Date signed 5/12/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 16 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05366 302  
Reg. Dist. No.

<b>1. PLACE OF DEATH:</b> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>30 years</u> Hospital, institution, or street address where death occurred: <u>614 Washington Ave.</u> How long in hospital or institution?				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State <u>Maryland</u> County <u>Washington</u> City or town <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>614 Washington Ave.</u> (If rural, give LOCATION) <u>None</u> 2.(a) If veteran, name war			
<b>3. (a) FULL NAME</b> <u>Jacob L. Kendall</u>				<b>3. (b) Social Security Number</b> <u>None</u>			
<b>4. Sex</b> <u>Male</u>		<b>5. Color or race</b> <u>White</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>Widowed</u>			
<b>6. (b) Name of husband or wife</b> <u>Ida N. Kendall</u>				<b>6. (c) If alive, give age</b> ..... years			
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>June 1. 1867</u>				<b>8. AGE:</b> Years <u>78</u> Months <u>11</u> Days <u>13</u> If less than one day ..... hrs. .... min.			
<b>9. Birthplace</b> <u>Williamsport Wash. Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>Foreman</u>			
<b>11. Industry or business</b> <u>Potomac Edison Co.</u>				<b>12. Name</b> <u>John Kendall</u>			
<b>13. Birthplace</b> <u>Funkstown Md.</u>				<b>14. Maiden name</b> <u>Cornelia Sister</u>			
<b>15. Birthplace</b> <u>Williamsport Md.</u>				<b>16. Informant</b> <u>Mrs. William Price</u> Address <u>Hagerstown Md.</u>			
<b>17. Burial</b> (Burial, cremation, or removal, Which?) <u>May 17. 1945</u> (month) (day) (year) Cemetery or crematory <u>Funkstown Cemetery</u> <u>Funkstown Md.</u> Location <b>18. Funeral director</b> <u>Scott F. Minnich &amp; Sons</u> Address <u>Hagerstown Md.</u>				<b>20. DATE OF DEATH</b> <u>May</u> <u>14</u> <u>19</u> <u>45</u> <u>9</u> <u>a</u> <u>M</u> <b>21. I CERTIFY</b> that death occurred on the date above stated; that I attended deceased from <u>Jan 14</u> <u>1945</u> to <u>May 14</u> <u>45</u> and that I last saw him alive on <u>May 14 - 45</u> Immediate cause of death <u>Cerebral Hemorrhage</u> <u>Active ulcer</u> Other conditions (Include pregnancy within 3 months of death) Major findings of operations Date of op. Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.			
<b>22. VIOLENCE:</b> If death was due to external causes, fill in the following: Accident, suicide, or homicide Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?				<b>23. SIGNATURE</b> <u>EW Powers</u> <u>Hagerstown</u> Address Date signed <u>May 15</u> <u>45</u>			

(Date rec'd by registrar)

Registrar

M. D. or other

Date signed

RECEIVED  
MAY 17 1945  
BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (1312)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 9 Years  
 Hospital, institution, or street address where death occurred:  
713 West Washington St.  
 How long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 713 West Washington St.  
 (If rural, give LOCATION)  
 2. (a) If veteran, name war None

## 3. (a) FULL NAME

Mrs. Amanda Elizabeth Kretzer

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow  
 6. (b) Name of husband or wife Jacob  
 6. (c) If alive, give age - years  
 7. Birth date of deceased (mo., day, yr.) May 30 1865  
 8. AGE: Years 79 Months 11 Days 20 If less than one day - hrs. - min.

9. Birthplace Myersville Fred. Co. Md.  
 (Town, county, and state)  
 10. Usual occupation Housewife  
 11. Industry or business Own Home  
 12. Name Ezra Biser  
 13. Birthplace Myersville Md.  
 14. Maiden name Ellen Detrow  
 15. Birthplace Myersville Md.

18. Informant Paul Kretzer  
 Address Hagerstown Md.  
 17. Burial Burial Date thereof 5/22/45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
 Location Hagerstown Md.  
 18. Funeral director Andrew K. Coffman  
 Address Hagerstown Md.

19. May 21 45 Registrar Charles H. Bowers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 1945 19 - at 2.30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May - 19 44 to May 20 - 19 45  
 and that I last saw her alive on May 20 - 19 45

Immediate cause of death Exsanguinating Heart -

Due to Chs. Vascular -

Due to -

Other conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -

Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide - Date of -

Where did injury occur? - (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -

Means of injury - Injured at work? -

23. SIGNATURE Amanda Kretzer M. D. or other -  
 Address Hagerstown Md. Date signed 5/21/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Kretzer 302

RECEIVED

MAY 23 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 29-2

## CERTIFICATE OF DEATH

05368

Reg. Dist. No. 316

## 1. PLACE OF DEATH:

County.....Washington.....City or town.....Rural Keedysville.....  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death?.....Life.....

Hospital, institution, or street address where death occurred:

How long in hospital or institution?.....

## 3. (a) FULL NAME

Tyson L. Lewis

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....Maryland..... County.....Wash......City or town.....Rural Keedysville.....  
(If outside city or town limits, write RURAL and give nearest town)Street No.....  
(If rural, give LOCATION)

2. (a) If veteran, name war.....

## 3. (b) Social Security Number

220-10-3812

## 4. Sex

Male

## 5. Color or race

Colored

## 6. (a) Single, married, widowed, or divorced

Widowed6. (b) Name of husband or wife.....Deceased.....

6. (c) If alive, give age.....years

## 7. Birth date of

deceased (mo., day, yr.)

May 7. 1870

## 8. AGE:

Years

75

Months

0

Days

17

If less than one day

.....hrs. ....min.

9. Birthplace.....Mt. Briar - Wash. - Maryland.....  
(Town, county, and state)10. Usual occupation.....Laborer.....

## 11. Industry or business

## FATHER

## 12. Name

Morris Lewis

## 13. Birthplace

Mt. Briar, Md.

## MOTHER

## 14. Maiden name

Unknown

## 15. Birthplace

"16. Informant.....Mrs. Annie Marie Cox.....

## Address

Keedysville, Md17. Burial..... Date thereof.....5.....27.....1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory.....Mt. Briar.....Location.....Mt. Briar Maryland.....18. Funeral director.....R. I. Earnshaw.....

## Address

Keedysville, Md19. May 21.....1945.....R. I. Earnshaw  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....May 24.....1945.....at 4:45.....A......M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23.....1945.....to.....May 24.....1945  
and that I last saw him alive on.....May 23.....1945

Immediate cause of death.....

Coronary Thrombosis

## DURATION

2 days

Due to.....

Arterial HypertensionCont. Long

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE.....Richard Wade M.D......  
M. D. or otherAddress.....R. I. Earnshaw, Md...... Date signed.....5/24/45.....

RECEIVED  
MAY 28 1945  
BUREAU V.I.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 163-H

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 14 years  
 Hospital, institution, or street address where death occurred:  
16 S. Mulberry Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 16 S. Mulberry Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Madge B. Lynn

## 3. (b) Social Security Number

214-09-5817

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife Harold Lynn  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) Nov. 2, 1910  
 8. AGE: Years 34 Months 6 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Shenandoah, Va.  
 (Town, county, and state)

10. Usual occupation Shoe Factory Employee

## 11. Industry or business

FATHER 12. Name Charles Baylor

13. Birthplace Rileyville, Va.

MOTHER 14. Maiden name Rena Woods

15. Birthplace Rileyville, Va.

16. Informant Harold Lynn  
 Address 16 S. Mulberry Street- Hagerstown, Md.

17. Burial Date thereof June 2, 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Methodist Cemetery

Location Shenandoah, Va.

18. Funeral director Fred W. Kraiss

Address Hagerstown, Md.

19. June 1, 1945 Registrar Clayton Powers  
 (Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 30, 1945 at 4 p.m. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from \_\_\_\_\_ 19\_\_\_\_, to \_\_\_\_\_ 19\_\_\_\_  
 and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_

Illuminating gas poisoning

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: May 30/45

Accident, suicide, or homicide suicide Date of \_\_\_\_\_

Where did injury occur? Hagerstown, Md.  
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) Home

Means of injury Gas stove Injured at work? No

DEPUTY MEDICAL EXAM. F. Robert Wells

23. SIGNATURE \_\_\_\_\_ WASH. CO., MD.  
 M. D. or other \_\_\_\_\_

Address Hagerstown, Md. Date signed 6/1/45

RECEIVED  
JUN 4 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Beachley

05370

Reg. Dist. No. 303

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 Days

Hospital, institution, or street address where death occurred:

Washington County HospitalHow long in hospital or institution? 3 Days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 743 Guilford Ave  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3.(a) FULL NAME

Mrs. Goldie Irene Martin

## 3.(b) Social Security Number

220-18-2518

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Robert C. Martin Sr.6.(c) If alive, give age 45 years

7. Birth date of

deceased (mo., day, yr.)

May 2 1902

8. AGE:

Years

Months

Days

It less than one day

43013

.....hrs. ....min.

9. Birthplace Chewsville Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Quiller

11. Industry or business

Federal Silk Mill

MOTHER FATHER

12. Name

Otho R. Smith

13. Birthplace

Smithsburg Md.

14. Maiden name

Flora E. Kuhn

15. Birthplace

Smithsburg Md.16. Informant Robert C. Martin Sr.

Address

Hagerstown Md.

17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

5/17/45

(month) (day) (year)

Cemetery or crematory

Smithsburg Cemetery

Location

Smithsburg Md.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.

19. May 16

(Date rec'd by registrar)

45

Frank Bowser

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 15 1945 19... at 2 A M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

and that I last saw him alive on May 15 1945 19...Immediate cause of death Myocardial Infarction

DURATION

3 days

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

Dr. Beachley M. D. or the Hagerstown, Md. Date signed May 17/45

RECEIVED  
MAY 18 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 305

## 1. PLACE OF DEATH:

County... WashingtonCity or town... Rural Boonsboro  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 1/2 yrs.

Hospital, institution, or street address where death occurred:

Fehrney Memorial Home

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Md. County... FredrickCity or town... Rural Middletown  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)2.(a) If veteran, name war no

## 3. (a) FULL NAME

Laura E. McBride

## 3. (b) Social Security Number

no

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed

6.(b) Name of husband or wife

Albert McBride

7. Birth date of

deceased (mn., day, yr.) Sept. 13, 1866

6.(c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

7888

.....hrs. ....min.

9. Birthplace... Boonsboro, Washington Co., Md.  
(Town, county, and State)10. Usual occupation... Retired (House wife)

11. Industry or business

12. Name... Jacob Ridenour13. Birthplace... Unknown, Md.14. Maiden name... Unknown15. Birthplace... Unknown16. Informant... Roy E. McBrideAddress... Burkittsville, Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof... May 24, 45  
(month) (day) (year)Cemetery or crematory... Reform CemeteryLocation... Middletown, Md.18. Funeral director... Chadwell Co.Address... Middletown, Md.19. May 23  
(Date rec'd by registrar)19. 45 John H. Bast  
Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 21 19... 45 at 8 P. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20 19... 45 to May 21 19... 45  
and that I last saw him... May 21 19... 45

Immediate cause of death

Carcinoma of Colon

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

G. W. Libby M.D.

M. D. or other

Address... Boonsboro, Md.Date signed... 5/23/45

RECEIVED  
MAY 25 1945  
BUREAU V. E.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 720

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 40 years  
 Hospital, institution, or street address where death occurred:  
335 West Washington Street  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 335 West Washington Street  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Owen Hugh McDevitt

## 3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) April 25, 1867 8. (c) If alive, give age \_\_\_\_\_ years

8. AGE: Years 78 Months 0 Days 10 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Hagerstown, Wash. Co. Md.

(Town, county, and state)

10. Usual occupation Retired Merchant

11. Industry or business

12. Name Owen McDevitt13. Birthplace Cather Ireland14. Maiden name Catherine Kennedy15. Birthplace Ireland16. Informant Mrs. Maud C. MoatsAddress Hagerstown, Maryland

17. Burial Date thereof 5-7-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill CemeteryLocation Hagerstown, Maryland18. Funeral director C. M. Suter & SonsAddress Hagerstown, Maryland

19. May 7 1945 Black Powers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH 5/5 1945 at 4 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 15 1945 to 5/5 1945  
 and that I last saw him alive on 5/4 1945

Immediate cause of death Arterio Sclerosis  
Chronic Endocarditis } 91  
 DURATION

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE V. H. Skullen M. D. or otherAddress W. WASHINGTON ST. Date signed 5/5 1945

HAGERSTOWN, MD.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 9 1945

BUREAU

Evidence for change of  
age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 33

05373

T

FILM No. G 95 MAY 29 1945

CERTIFICATE OF DEATH

Reg. Dist. No. 30-2

1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 3 weeks  
Hospital, institution, or street address where death occurred:  
Washington County Hospital  
How long in hospital or institution? 3 weeks

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 224 N. Jonathan St  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

3. (a) FULL NAME

Richard Calvin Miller

3. (b) Social Security Number

4. Sex Male 5. Color or race Cal 6. (a) Single, married, widowed, or divorced Single  
6. (b) Name of husband or wife none  
7. Birth date of deceased (mo., day, yr.) Oct 5 1877 6. (c) If alive, give age..... years  
8. AGE: Years 68 Months 67 Days..... It less than one day..... hrs. .... min.

9. Birthplace Hagerstown  
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER 12. Name George C. Miller  
13. Birthplace.....

MOTHER 14. Maiden name Mollie Hill Miller  
15. Birthplace.....

16. Informant Petty Jones  
Address 224 N. Jonathan St

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 7, 45  
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery  
Location Hagerstown

18. Funeral director William H. Downing  
Address 291 Frederick St

19. May 7 45 (Date recd by registrar) Registrar Bluff Powers

MEDICAL CERTIFICATION

20. DATE OF DEATH 5/3 19 45 at 12:45 M  
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 - 19 45 to 5/3 19 45  
and that I last saw him alive on 5/2 19 45

Immediate cause of death myocarditis  
chronic arterio-sclerosis DURATION 1 month? (?)

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

..... Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Victor D. Miller  
VICTOR D. MILLER M. D. or other

Address 181 W. WASHINGTON ST. Date signed 5/5/1945

HAGERSTOWN, MD.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 9 1945  
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?... 27 years  
 Hospital, institution, or street address where death occurred:  
616 Potomac Avenue  
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 616 Potomac Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Robert Raymond Miller

## 3. (b) Social Security Number

214-09-6949

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife... Helena Olivivette Miller  
 6.(c) If alive, give age... 62 years  
 7. Birth date of deceased (mo., day, yr.) October 15, 1891  
 8. AGE: Years 53 Months 6 Days 25 If less than one day  
 .....hrs. ....min.

9. Birthplace... York, York Co. Pa.  
 (Town, county, and state)  
 10. Usual occupation... Insurance Salesman  
 11. Industry or business... Monumental Life Ins. Co.  
 12. Name... Henry Miller  
 13. Birthplace... Goldsboro, Pa.  
 14. Maiden name... Susan Prowell  
 15. Birthplace... Valley Fishing Creek, Pa.

16. Informant... Mrs. Raymaond Miller  
 Address... Hagerstown, Maryland  
 17. Burial Date thereof... 5-12-45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Rose Hill Cemetery  
 Location... Hagerstown, Maryland  
 18. Funeral director... C. M. Suter & Sons  
 Address... Hagerstown, Maryland  
 19. May 12 19 45 Phaedra Edwards  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 10 19 45, at 3 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
 .....19....., to .....19.....  
 and that I last saw him alive on .....19.....

Immediate cause of death..... DURATION  
Coronary occlusion  
 Due to.....  
 Due to.....  
 Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations... None Date of op. ....  
 Autopsy results... None  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... No Date of .....  
 Where did injury occur? ..... (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?) .....  
 Means of injury ..... Injured at work? .....

23. SIGNATURE... S. P. Edwards DEPUTY MEDICAL EXAM.  
Hagerstown, Md. WASH. CO., MD.  
 M. D. 3/4/45  
 Address... Date signed...

RECEIVED  
MAY 15 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

05375

Reg. Diat. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Baguetown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 yr

Hospital, institution or street address where death occurred:

137 Ray St. Baguetown, Md.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Fredericktown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 137 Ray St. Hagerstown  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Adam Neal

## 3. (b) Social Security Number

None4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced married6. (b) Name of husband or wife Hennetta Wendal Neal7. Birth date of deceased (mo., day, yr.) Aug 31 1867 6. (c) If alive, give age 74 years8. AGE: Years 77 Months 5 Days 12 If less than one day  
..... hrs. .... min.9. Birthplace Illinois  
(Town, county, and state)10. Usual occupation Farming11. Industry or business S & Neal12. Name Adam Neal13. Birthplace Unknown14. Maiden name Eliza J. Charlton15. Birthplace Washington16. Informant Mrs. Leta L. HagerstownAddress Baguetown, Md.17. Buried Date thereof 5/15/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematorium Leiterburg CemeteryLocation Leiterburg, Md.18. Funeral director E. T. ReescherAddress Funkhouser, Md.19. May 14 19 45 Phyllis Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 12, 1945, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 5, 1945 to May 12, 1945and that I last saw him alive on May 12, 1945

Immediate cause of death

Coronary atherosclerosis

DURATION

2 mo.

Due to

Due to

Other conditions

Hypertensive cardio-vascular disease  
(Include pregnancy within 3 months of death)

Major findings of operations

No operations

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of Injury

Injured at work?

23. SIGNATURE

La Bell

M. D. or other

Address Hagerstown, Md.Date signed 5/14/45

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

NAME OF DECEASED

PLACE OF DEATH

RECEIVED

MAY 16 1945

BUREAU V.B.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 23 years

Hospital, institution, or street address where death occurred:

Wash. Co. HospitalHow long in hospital or institution? 8 weeks

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 617 - Highlandway  
(If rural, give LOCATION)2.(a) If veteran, name war none

## 3. (a) FULL NAME

Sarah Elizabeth Palmer

## 3. (b) Social Security Number

none

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

widowed8.(b) Name of husband or wife Edward L. Palmer

6.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) September - 21 - 18618. AGE: 83 Years 7 Months 26 Days hrs. min.  
If less than one day9. Birthplace Near Myerstown Fred. Co. Md.  
(Town, county, and state)10. Usual occupation Housekeeper11. Industry or business own homeFATHER 12. Name John Koogle13. Birthplace Near Myerstown Fred. Co. Md.MOTHER 14. Maiden name Rebecca Markes15. Birthplace Near Myerstown Fred. Co. Md.16. Informant Leone PalmerAddress 617 - Highland Way Hagerstown Md.17. Burial Date thereof May 19 - 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Lutheran CemeteryLocation Myerstown Md.18. Funeral director Wm. D. Bast & SonAddress Brownsville Md.19. May 18 19 45 617 - Highlandway  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 17 19 45 at 8:45 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 11 19 45 to May 17 19 45

and that I last saw him \_\_\_\_\_ alive on \_\_\_\_\_ 19 \_\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Hypostatic pneumonia 3 daysDue to Fracture of right femurDue to at hip jointOther conditions Generalized years  
arterio sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op. \_\_\_\_\_

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of 4/9/45Where did injury occur? Hagerstown Washington Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) At homeMeans of injury fell out of bed Injured at work? no23. SIGNATURE CB Yourenton M. D. or other \_\_\_\_\_Address Hagerstown Md. Date signed 5/18/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. N. Mount

RECEIVED  
MAY 21 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (13-2)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 1 day  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?..... 1 day

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County.....  
 City or town..... Near Bridgeport  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No..... Cavetown Pike  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Sarah Ellen Eakle Plummer

## 3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White widowed6. (b) Name of husband or wife Charles W. Plummer7. Birth date of deceased (mo., day, yr.) April 2, 18668. AGE: Years Months Days If less than one day  
79 0 29 .....hrs. ....min.9. Birthplace..... Maryland  
(Town, county, and state)10. Usual occupation..... Housewife

## 11. Industry or business

12. Name..... Jacob Eakle13. Birthplace..... Maryland14. Maiden name..... Sarah Eakle Baechtell15. Birthplace..... Maryland16. Informant..... Mr. S. B. PlummerAddress..... Bridgeport17. Burial Date thereof..... May 4, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory..... Shiloh United BrethrenLocation..... Near Bridgeport18. Funeral director..... Charles R. BastAddress..... Hancock, Md.19. May 4, 1945 Baecht-Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 1st 1945, at 8:45 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
April 29 1945, to May 1st 1945,  
and that I last saw her alive on May 1st 1945.

Immediate cause of death.....

DURATION

Mitral Stenosis 5 yrs.  
 Due to.....  
Arteriosclerosis 5 yrs.  
 Due to.....  
Chr. Intralobular Nephritis 5 yrs.  
 Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur?.....  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury..... Injured at work?

23. SIGNATURE..... Ernest F. Proctor  
M. D. or otherAddress..... Hagerstown, Md. Date signed..... 5/3/45

RECEIVED

MAY 7 1945

BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (125-6)

## CERTIFICATE OF DEATH

05378

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL NEAR and give town)  
Street address, hospital, or institution:  
Washington County Hospital  
Stay in hospital or inst. (yrs., or mos., or days) 44 days  
Stay in this community (yrs., or mos., or days) \_\_\_\_\_

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State West Virginia County Berkeley  
City or town Martinsburg, W. Va. Ward No. \_\_\_\_\_  
(If outside city or town limits, write RURAL NEAR and give town)  
Street No. 223 Russler St.  
(If rural give LOCATION)  
2(a) IF VETERAN, NAME WAR \_\_\_\_\_ ✓

### 3. (a) FULL NAME

Theodore J. Price

### 3. (b) Social Security Number

233-09-2493

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6 (b) Name of husband or wife Sarah A. Hendricks

7. Birth date of deceased (mo., day, yr.) Nov. 11, 1904

8. AGE: Years 40 Months 6 Days 21 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Berkeley Co., W. Va.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name William Price

13. Birthplace Berkeley Co., W. Va.

14. Maiden name Mary E. Schoppert

15. Birthplace Berkeley Co., W. Va.

16. Informant Mrs. Sarah A. Price  
223 Russler St., Martinsburg,  
Address W. Va.

17. Removal Date thereof May 5, 1945  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory New Norbin Cemetery

Location Martinsburg, W. Va.

18. Funeral director H. K. Brown

Address Martinsburg, W. Va.

19. May 3 1945 Christ H. Bowers  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 2, 1945, at 10:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from March 16, 1945 to May 2, 1945

and that I last saw him alive on \_\_\_\_\_ 19\_\_\_\_

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Perforated ascending colon

and post peritoneal abscess

Due to with abscess of liver Oct '44

Due to Bronchopneumonia 4 days

Other conditions \_\_\_\_\_

(Include pregnancy within 3 months of death)

Major findings: post peritoneal abscess PHYSICIAN \_\_\_\_\_

Of operations \_\_\_\_\_ Please underline the cause to which death should be charged statistically.

Of autopsy as above 5/2/45

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE A. Robert Wells M.D.

Hagerstown, Md. M. D. or other \_\_\_\_\_

Address \_\_\_\_\_ Date signed 5/2/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 5 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

Reg. Dist. No. 05372 304

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? Life 83 Years  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hancock  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. ....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war .....

## 3.(a) FULL NAME

Gillmore Seville

## 3.(b) Social Security Number

NONE

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed  
 6.(b) Name of husband or wife... Ida Seville  
 8.(c) If alive, give age... years  
 7. Birth date of deceased (mo., day, yr.) September 8 1861  
 8. AGE: Years 83 Months 8 Days 17 If less than one day  
 ....hrs. ....min.

8. Birthplace... Washington Co.  
 (Town, county, and state)  
 10. Usual occupation... Carpenter  
 11. Industry or business  
 12. Name... Arthur Seville  
 13. Birthplace... Washington Co.  
 14. Maiden name... Anna R. Myers  
 15. Birthplace... Washington Co.  
 18. Informant... William Seville  
 Address... Hancock, Md.

17. Burial Date thereof... May 27 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory... Presbyterian  
 Location... Hancock.  
 18. Funeral director... Snyder - Rowland  
 Address... Hancock, Md.  
 19. 5/25 1945 J. H. Helms  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 25 1945 at 1:15 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from  
May 1 1945 to May 25 1945  
 and that I last saw him/her alive on May 25 1945

Immediate cause of death  
Chronic myocarditis  
Arteriosclerosis  
 Due to...  
 Due to...  
 Other conditions...  
 (Include pregnancy within 8 months of death)

Major findings of operations...  
 Date of op...  
 Autopsy results...  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide... Date of...  
 Where did injury occur? (City or town) (County) (State)  
 Injured at home, farm, industry, public place (where?)  
 Means of injury Injured at work?

23. SIGNATURE... M. Shaffer M.D.  
Hancock Md. M. D. or other  
 Address... Date signed 5/25/45

UNITED STATES DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED  
MAY 29 1945  
BUREAU V.S.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 740

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County..... Washington  
City or town..... Hagerstown, Maryland  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?..... Life  
Hospital, institution, or street address where death occurred:  
64 Madison Avenue  
How long in hospital or institution?.....

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State..... Maryland County..... Washington  
City or town..... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)  
Street No..... 64 Madison Avenue  
(If rural, give LOCATION)  
2.(a) If veteran, name war.....

### 3. (a) FULL NAME

Samuel C. Geogrey Shoemaker

### 3. (b) Social Security Number

214-09-6265

4. Sex..... Male  
5. Color or race..... White  
6.(a) Single, married, widowed, or divorced..... Married

6.(b) Name of husband or wife..... Margaret Shoemaker

6.(c) If alive, give age..... 55 years

7. Birth date of deceased (mo., day, yr.)..... February 19, 1880

8. AGE: Years..... 65 Months..... 4 Days..... 11  
If less than one day..... hrs. .... min.

9. Birthplace..... Millstone, Wash.Co.Md.  
(Town, county, and state)

10. Usual occupation..... Laborer

11. Industry or business..... Colonial Hardwood Flooring

12. Name..... Samuel Shoemaker

13. Birthplace..... Hancock, Maryland

14. Maiden name..... Elizabeth Williams

15. Birthplace..... Little Cove, Maryland

16. Informant..... Mrs. Samuel Shoemaker

Address..... Hagerstown, Maryland

17. Burial..... Date thereof..... 6-2-45  
(Burial, cremation, or removal. Which?)..... (month) (day) (year)

Cemefery or crematory..... Rose Hill Cemetery

Location..... Hagerstown, Maryland

18. Funeral director..... C. M. Suter & Sons

Address..... Hagerstown, Maryland

19. June 1, 1945.....  
(Date rec'd by registrar)..... Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 30, 1945, at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from..... 19..... to..... 19.....  
and that I last saw h..... alive on..... 19.....

Immediate cause of death.....

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town)..... (County)..... (State).....

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?.....

23. SIGNATURE..... DEPUTY MEDICAL EXAMINER

Address..... WASH. CO., MD.

Date signed.....

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
JUN 4 1945  
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 302

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
Washington County Hospital  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State Maryland County Washington  
 City or town Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 436 Carrollton Avenue  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war

## 3. (a) FULL NAME

Alice R. Smith

## 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Married  
 6.(b) Name of husband or wife William F. Smith  
 6.(c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) August 11, 18 93  
 8. AGE: 51 Years 9 Months 12 Days If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Washington County, Md.  
 (Town, county, and state)  
 10. Usual occupation Home Duties  
 11. Industry or business

12. Name Abraham Mills  
 13. Birthplace Wash. Co., Md.  
 14. Maiden name Emma Cunningham  
 15. Birthplace Wash. Co., Md.

16. Informant William F. Smith  
 Address 436 Carrollton Ave.-Hagerstown  
 17. Burial Date thereof May 26, 45  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory Rose Hill Cemetery  
Hagerstown, Md.  
 Location

18. Funeral director Fred W. Kraiss  
 Address Hagerstown, Md.

19. May 26 19 45 Charles H. Bowers  
 (Date rec'd by Registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 23, 1945 3:25 P. at M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 4/23/45 1945 to 5/23/45 1945  
 and that I last saw him/her alive on 5/23/45 1945

Immediate cause of death Cerebral Apoplexy  
 Due to Fallo-Paresis

Other conditions \_\_\_\_\_  
 (Include pregnancy within 8 months of death)  
 Major findings of operations \_\_\_\_\_  
 Date of op. \_\_\_\_\_  
 Autopsy results \_\_\_\_\_  
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:  
 Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_  
 Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)  
 Injured at home, farm, industry, public place (where?) \_\_\_\_\_  
 Means of injury \_\_\_\_\_ Injured at work?

23. SIGNATURE C. F. Goring  
Will Amstutz  
 Address \_\_\_\_\_ Date signed 5/23/45

05381

RECEIVED  
MAY 29 1945  
BUREAU V.F.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

## CERTIFICATE OF DEATH

Reg. Dist. No. 05382 307

### 1. PLACE OF DEATH:

County Washington  
City or town near Rohersville Rural  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 5 yrs.  
Hospital, institution, or street address where death occurred:  
Rohersville md. R. 1  
How long in hospital or institution? at home

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town near Rohersville Rural  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Rohersville md. R. 1.  
(If rural, give LOCATION)  
2. (a) If veteran, name war none

### 3. (a) FULL NAME

Jacob Luther Smith

### 3. (b) Social Security Number

none

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married  
6. (b) Name of husband or wife Mrs. Cora M. Smith  
7. Birth date of deceased (mo., day, yr.) August 17 - 1879 8. (c) If alive, give age years  
8. AGE: Years 65 Month 9 Day 3 It less than one day hrs. min.

9. Birthplace near Rohersville Wash. Co. md.  
(Town, county, and state)

10. Usual occupation Farmer

### 11. Industry or business

12. Name Winfield Scott Smith

13. Birthplace near Rohersville Wash. Co. md.

14. Maiden name Hannah L. Long

15. Birthplace near Rohersville Wash. Co. md.

16. Informant Mrs. Cora M. Smith

Address Rohersville md.

17. (Burial, cremation, or removal. Which?) Burial Date thereof May 23, 1945  
(month) (day) (year)

Cemetery or crematory Locust Grove Cemetery

Location Locust Grove md.

18. Funeral director Wm. J. Bost & Sons

Address Baltimore md.

19. May 22 19 45 Mrs. Katherine Dugan  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 20 19 45 at 11:00 P - M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 15 19 43 to May 20 19 45

and that I last saw him alive on May 18 19 45

Immediate cause of death Diabetes mellitus DURATION 2 yrs

Due to Arteriosclerosis DURATION 2 yrs

Due to Arteriosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Isabel Mader M.D. M. D. or other

Address Baltimore md. Date signed 5/21/45

MARGIN RESERVED FOR BINDING

VS 476

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Dr. Wade

RECEIVED

RECEIVED

RECEIVED  
MAY 24 1945  
BUREAU V.B.

3

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

05383

Reg. Dist. No. 305

### 1. PLACE OF DEATH:

County Washington  
City or town San Mar  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death? 10 months  
Hospital, institution, or street address where death occurred:  
Jahney Memorial Home  
How long in hospital or institution? 10 months

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
State Maryland County Baltimore  
City or town Baltimore  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. 3104 Spaulding ave.  
(If rural, give LOCATION)  
2.(a) If veteran, name war None

### 3. (a) FULL NAME

Leila B. Smith

### 3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife David R. Smith  
6.(c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) September - 1 - 1868

8. AGE: Years 76 Months 8 Days 0 If less than one day hrs. min.

8. Birthplace near Wilson Wash. Co. Md.  
(Town, county, and state)

10. Usual occupation None

11. Industry or business

FATHER 12. Name Samuel C. Brewer  
13. Birthplace Wash. Co. Md.

MOTHER 14. Maiden name Angelica Huxett  
15. Birthplace West Virginia

16. Informant Mrs. W. J. Wills  
Address 420 W. Franklin St. Hagerstown Md.

17. Burial Date thereof May 3, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory St. Pauls Cemetery  
Location near Clarksburg Md.

18. Funeral director Wm. E. East & Sons  
Address Broomfield Md.

19. May 3, 19 45 John H. Bask  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 1 19 45 at 11 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 3 19 45, to May 1 19 45  
and that I last saw him alive on April 27 19 45

Immediate cause of death

Chronic Myocarditis DURATION 3 yrs

Due to Chronic arteriosclerosis 10 yrs

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE J. W. Selan M.D.  
Address Broomfield M. D. or other 5/2/45

Date signed

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 9 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age is shown on

FILM No. G 95 JUN 13 1945

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 3 weeks

Hospital, institution, or street address where death occurred:

311 N. Franklin St.

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County Washington

City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 311 N. Franklin St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (a) FULL NAME

Lewis Fleet  
Benjamin Smith

### 3. (b) Social Security Number

#### 4. Sex

male

#### 5. Color or race

white

#### 6. (a) Single, married, widowed, or divorced

married

#### 6. (b) Name of husband or wife

Lottie Ambrose

6. (c) If alive, give age 61 years

#### 7. Birth date of deceased (mo., day, yr.)

Dec. 4, 1883

#### 8. AGE:

Years

Months

Days

If less than one day

61

62

5

24

hrs.

min.

#### 9. Birthplace

Essex, Maryland  
(Town, county, and state)

#### 10. Usual occupation

Labor

#### 11. Industry or business

FATHER  
MOTHER

#### 12. Name

Sus. Smith

#### 13. Birthplace

Fredrick Co. Md.

#### 14. Maiden name

Susan F. Ambrose

#### 15. Birthplace

unknown Fred. Co. Md.

#### 16. Informant

Mr. Lottie A. Smith

#### Address

34 N. Franklin St. Hagerstown, Md.

#### 17.

(Burial, cremation, or removal. Which?)

Date thereof

5/29/45  
(month) (day) (year)

#### Cemetery or crematory

Hagerstown

#### Location

Hagerstown Co. #4

#### 18. Funeral director

Walter J. Jone

#### Address

270 N. Charles St. Hagerstown, Md.

#### 19.

May 27, 1945

(Date rec'd by registrar)

Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 27 19 45 at 10A M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., to.....19.....

and that I last saw h.....alive on.....19.....

Immediate cause of death

angina pectoris

#### DURATION

1 yr

Due to

acute coronary occlusion

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

no

Date of op.

Autopsy results

no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

no

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Injured at work?

Means of injury

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

23. SIGNATURE

S. R. Hager

M. D. of

Hagerstown, Md.

Date signed May 27/45

RECEIVED

MAY 29 1945

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (931)

## CERTIFICATE OF DEATH

Dr. Bjikley T

05385

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 9 Weeks

Hospital, institution, or street address where death occurred:

Washington County Hospital

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 106 East Antietam St.

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (a) FULL NAME

William Aldine Snyder

## 3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married6.(b) Name of husband or wife Carrie6.(c) If alive, give age 79 years

7. Birth date of

deceased (mo., day, yr.) September 17 1863

8. AGE:

Years

81

Months

7

Days

24

If less than one day

hrs. min.9. Birthplace Hagerstown Wash. Co. Md

(Town, county, and state)

10. Usual occupation

Merchant

11. Industry or business

Retired

FATHER

12. Name

John Snyder

13. Birthplace

Hagerstown Md.

MOTHER

14. Maiden name

Louise Kemp

15. Birthplace

Hagerstown Md.16. Informant Mrs. Carrie Snyder

Address

Hagerstown Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof 5/13/45

(month) (day) (year)

Cemetery or crematory

Cedar Hill Cemetery

Location

Greencastle Pa.

18. Funeral director

Andrew K. Coffman

Address

Hagerstown Md.19. May 12 1945  
(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 1945 at 3 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2 1945 to May 11 1945  
and that I last saw him alive on May 11 1945

Immediate cause of death

acute myocardial failure

DURATION

5 days

Due to

Chr Myocarditis with Hypertrophy10 yrs

Due to

Other conditions

Arterio Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. Bjikley M. D.Address Hagerstown, Md. Date signed 5/2/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 15 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93d)

## CERTIFICATE OF DEATH

Reg. Dist. No. 05380302

## 1. PLACE OF DEATH:

County Washington  
 City or town Beaver Creek Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 6 months  
 Hospital, institution, or street address where death occurred:  
Hagerstown Md. R.1  
 How long in hospital or institution? at home

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residences of mother)  
 State Maryland County Washington  
 City or town Beaver Creek Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. Hagerstown Md. R.1  
 (If rural, give LOCATION)  
 2(a) If veteran, name war None

## 3. (a) FULL NAME

Celia Catherine Staley

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

8. (b) Name of husband or wife

David J. Staley

7. Birth date of

deceased (mo., day, yr.)

September - 1 - 1867

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

7782

hrs.

min.

9. Birthplace

Mountaineale Fred. Co. Md.  
(Town, county, and state)

10. Usual occupation

Housekeeper

11. Industry or business

Own home

FATHER

MOTHER

12. Name

William M. Stoll

13. Birthplace

Fred. Co. Md.

14. Maiden name

Anna Rebecca Portgahn

15. Birthplace

Fred. Co. Md.

16. Informant

Edwin Staley

Address

Hagerstown Md. R.1

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 7, 1945  
(month) (day) (year)

Cemetery or crematory

Mt. Olivet Cemetery

Location

Fredrick Md.

18. Funeral director

Wm. J. Best & Sons

Address

Boonsboro Md.

19.

(Date rec'd by registrar)

May 5 1945

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

May 3 45 19. at 2:30 PM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 - 45 19. to May 3 45and that I last saw her alive on May 3 45 19.

Immediate cause of death

Ch. Myocarditis

DURATION

5 yrs

Due to

Due to

Arteriosclerosis4 mths

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. Physician

Address

Date signed

RECEIVED  
MAY 8 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... Washington  
 City or town... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

1029 Spruce St.

How long in hospital or institution?

30 days

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)Street No. 1029 Spruce St.  
 (If rural, give LOCATION)2.(a) If veteran, name war... None

## 3. (a) FULL NAME

Mary Rebecca Ellen Stoner

## 3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife... Samuel J

7. Birth date of

deceased (mo., day, yr.)

March 2 18708. (c) If alive, give age... 65 years

8. AGE:

Years

75

Months

2

Days

25

If less than one day

hrs.

min.

9. Birthplace...

Burkettville Fredrick Co. Md.

(Town, county, and state)

10. Usual occupation...

Housewife

11. Industry or business

Own home

FATHER

12. Name

Charlton Fogle

13. Birthplace

Liberty Md.

MOTHER

14. Maiden name

Mary C Matthews

15. Birthplace

Thurmont Md.

16. Informant

Samuel J Stoner

Address

1029 Spruce St.United Brethern

17.

(Burial, cremation, or removal. Which?)

Date thereof

May 30 1945  
 (month) (day) (year)

Cemetery or crematory

Burial

Location

Thurmont Maryland

18. Funeral director

M L Creager & Son

Address

Thurmont Maryland

19.

(Date rec'd by registrar)

May 29 1945  
Blas H Brown  
 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 27 19 45 at 11pm M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 23 19 45 to May 27 19 45  
 and that I last saw her alive on May 27 19 45

Immediate cause of death

Cerebral Hemorrhage

DURATION

5725/45

Due to

Hypertension  
arteriosclerosis

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE

H S Porterfield M.D.

M. D. or other

Address... 136 W Washington Date signed 5/29/45

RECEIVED

MAY 31 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

1. PLACE OF DEATH  
 County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 48 years  
 Hospital, institution, or street address where death occurred:  
114 E. Franklin St.  
 How long in hospital or institution? .....

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Maryland County... Washington  
 City or town... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 114 E. Franklin  
 (If rural, give LOCATION)  
None  
 2.(a) If veteran, name war.....

3. (a) FULL NAME  
Nora Mae Stouffer

3. (b) Social Security Number  
None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife William E. Stouffer  
 6. (c) If alive, give age 69 years

7. Birth date of deceased (mo., day, yr.) Feb. 6 1876

8. AGE: Years 69 Months 3 Days 22 If less than one day  
 .....hrs. ....min.

9. Birthplace Leitersburg Wash. Md.  
 (Town, county, and state)

10. Usual occupation House Wife

11. Industry or business Own Home

12. Name Charles M. Lantz

13. Birthplace Leitersburg Md.

14. Maiden name Sarah Zentmyer

15. Birthplace Leitersburg Md.

16. Informant Mr. William E. Stouffer

Address Hagerstown Md.

17. Burial Date thereof May 30 1945  
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rose Hill

Location Hagerstown Md.

18. Funeral director Scott F. Minnich & Son

Address Hagerstown Md.

19. May 29 45 Registrar Phyllis Bowers

(Date rec'd by registrar) 19. 45 Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 28 1945 at 12:53 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 3, 1926, to 19.....

and that I last saw h..... alive on 19.....

Immediate cause of death Cardiac-Renal Disease

Decomposition DURATION Jan. 1941

Due to Diabetes Mellitus 12 weeks.

Due to arteriosclerosis Jan. 1933

Other conditions .....

(Include pregnancy within 3 months of death)

Major findings of operations None

Date of op. None

Autopsy results Yes

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? X (City or town) X (County) X (State)

Injured at home, farm, industry, public place (where?) .....

Means of Injury .....

Injured at work? .....

23. SIGNATURE W. Howard Yeager

Address Hagerstown, Md. M. D. or other May 28, 1945

Date signed .....

RECEIVED

MAY 31 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (742)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown, Maryland  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

141 East Avenue

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. 141 East Avenue  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Patrick J. Sullivan

## 3. (b) Social Security Number

214-05-6759

4. Sex..... Male 5. Color or race..... White 6.(a) Single, married, widowed, or divorced..... Single

6.(b) Name of husband or wife.....

6.(c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.)

June 28, 1888

8. AGE: Years..... 56 Months..... 10 Days..... 16 If less than one day..... hrs. .... min.

9. Birthplace..... Derra Alta, W. Va.

(Town, county, and state)

10. Usual occupation..... Salesman11. Industry or business..... C. D. Kenny & Co.12. Name..... Patrick J. Sullivan13. Birthplace..... Ireland14. Maiden name..... Not Known15. Birthplace..... Ireland16. Informant..... Norman E. SellAddress..... Cumberland Md.17. Burial..... 5-16-45

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory..... St. Peter & St. PaulLocation..... Cumberland? Maryland18. Funeral director..... C. M. Suter & SonsAddress..... Hagerstown, Maryland

19. May 14 1945 Charles Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... May 14 1945 at 5 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

..... 19....., to..... 19.....

and that I last saw him..... alive on..... 19.....

Immediate cause of death.....

acute coronary occlusion

DURATION

2 1/2 hrs.

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations..... no

..... Date of op. ....

Autopsy results..... No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... No Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE.....

Address..... Hagerstown, Md. Date signed..... 5/14/45

DEPUTY MEDICAL EXAM.

WASH. CO., MD.

M. D. overruler

RECEIVED  
MAY 16 1945  
BUREAU V.F.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County... Washington  
City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred: on street

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Washington  
City or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 46 Blooms ave  
(If rural, give LOCATION)

2(a) If veteran, name war

### 3. (a) FULL NAME

Alfred Thomas

### 3. (b) Social Security Number

192-01-7865

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

Sept 25 1914

8. (c) If alive, give age years

8. AGE:

30

9. Birthplace America S.E.  
(Town, county, and state)

10. Usual occupation laborer

11. Industry or business

FATHER

12. Name Alfred Thompson

13. Birthplace Sparksburg D.C.

MOTHER

14. Maiden name Wine Sawyer

15. Birthplace Drumpler D.C.

16. Informant Florence Bains

Address 46 Blooms ave

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof May 30, 45  
(month) (day) (year)

Cemetery or crematory Rose Hill Cemetery

Location Hagerstown

18. Funeral director W.H. Dorney

Address 291 Frederick St.

19. May 31 19 45 Phat Howard  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH

May 25 19 45 at 7 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19... to 19...

and that I last saw him alive on 19...

Immediate cause of death

Ischemic heart disease  
Acute coronary  
occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

None Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

A. Robert Wells DEPUTY MEDICAL EXAM.  
WASH. CO., MD.

23. SIGNATURE M. D.

Address Hagerstown, Md. Date signed 5/29/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

JUN 2 1945

BUREAU V.S.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore *BfD*

## CERTIFICATE OF DEATH

05391 302  
Reg. Dist. No. *302*

## 1. PLACE OF DEATH:

County *Washington*  
 City or town *Hagerstown*  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street address, hospital, or institution:  
*Washington Co. Home*  
 Stay in hospital or inst. (yrs., or mos., or days) *8 months*  
 Stay in this community (yrs., or mos., or days) \_\_\_\_\_

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State *Penn.* County *Franklin*  
 City or town *State Line* Ward No. \_\_\_\_\_  
 (If outside city or town limits, write RURAL NEAR and give town)  
 Street No. \_\_\_\_\_ (If rural give LOCATION)  
 2(a) IF VETERAN, NAME WAR \_\_\_\_\_ ✓

## 3. (a) FULL NAME

*George F. Tressler*

## 3. (b) Social Security Number

*None*

4. Sex *Male* 5. Color or race *White* 6. (a) Single, married, widowed, or divorced *Widowed*  
 6 (b) Name of husband or wife *Sarah Elizabeth Ledy*  
 6 (c) If alive, give age \_\_\_\_\_ years  
 7. Birth date of deceased (mo., day, yr.) *May 30<sup>th</sup> 1865*  
 8. AGE: Years *79* Months *11* Days *16* If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace *Adams Co. Pa.*  
 (Town, county, and state)  
 10. Usual occupation *Carpenter*  
 11. Industry or business \_\_\_\_\_

12. Name *Jacob Tressler*  
 13. Birthplace *Adams Co. Pa.*  
 14. Maiden name *Margaret Kent*  
 15. Birthplace *Adams Co. Pa.*  
 16. Informant *A C Tressler*  
 Address *State Line Pa*

17. *Burial* Date thereof *5/18/45*  
 (Burial, cremation, or removal. Which?) (month) (day) (year)  
 Cemetery or crematory *Cedar Hill Cemetery*  
 Location *Freemantle Pa.*

18. Funeral director *Mrs. David Martin*  
 Address *Freemantle Pa.*

19. *May 17* 19 *45* *Chas. H. Bowers*  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH *May 16* 19 *45* at *5<sup>30</sup>* P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *May 1* 19 *45* to *May* 19 *45* and that I last saw him alive on *May 16* 19 *45*

Immediate cause of death

DURATION

*Arterio sclerosis* *5 yo.*

Due to *Chronic intestinal nephritis* *1 yr.*

Due to \_\_\_\_\_  
 Other conditions *Uremia* *1 wk.*

(Include pregnancy within 8 months of death)

Major findings:

Of operations \_\_\_\_\_

Of autopsy \_\_\_\_\_

22. VIOLENCE: If death was due to external causes, fill in the following;

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_

Injured at work? \_\_\_\_\_

23. SIGNATURE

*E. F. Tressler*

M. D. or other

Address *Hagerstown Md* Date signed *5/17/45*

MARGIN RESERVED FOR BINDING

VSA15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED MAY 19 1945

RECEIVED  
MAY 19 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, ~~WASH~~ UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1646

## CERTIFICATE OF DEATH

Dr. Wells

05392

Reg. Dist. No.

302

## 1. PLACE OF DEATH:

County WashingtonCity or town Funkstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 20 years

Hospital, institution, or street address where death occurred:

Beaver Creek Pike Antietam CreekHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Funkstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. Beaver Creek Pike  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Madilon Eloise Troxell

## 3. (b) Social Security Number

214-09-8237

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single6. (b) Name of husband or wife --5. (c) If alive, give age -- years7. Birth date of deceased (mo., day, yr.) December 31 1910

8. AGE: Years Months Days If less than one day

3451hrs.min.9. Birthplace Funkstown Wash. Co. Md.  
(Town, county, and state)10. Usual occupation Bookkeeper11. Industry or business Hagerstown Trust Co.12. Name J. F. Troxell13. Birthplace Funkstown Md.14. Maiden name Alice D. Reed15. Birthplace Funkstown Md.16. Informant Hugh G. TroxellAddress Funkstown Md.17. Burial Date thereof 5/24/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rest Haven CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 24 19 45 W. H. Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945 19 at 11:30 A

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

19 to 19 atand that I last saw him alive on 19 atImmediate cause of death Asphyxiation byDue to drowningDue to Other conditions 

(Include pregnancy within 3 months of death)

Major findings of operations NoneDate of op. Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 5/22/45Where did injury occur Funkstown Wash. Md.  
(City or town) (County) (State)Injured at home, farm, industry, public place (where?) Beaver CreekMeans of injury Jumped in creek Injured at work? NoDEPUTY MEDICAL EXAM. W. H. Bowers WASH. CO., MD.23. SIGNATURE W. H. Bowers M. D. or otherAddress Hagerstown, Md. Date signed 5/23/45

RECEIVED

MAY 25 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 302

1. PLACE OF DEATH: Washington  
 County...  
 City or town...  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 3 days  
 Hospital, institution, or street address where death occurred:  
 Washington Co Hospital  
 How long in hospital or institution? 3 days

2. USUAL RESIDENCE (HOME) OF DECEASED:  
 (For newborn infants give residence of mother)  
 State... Pa County... Franklin  
 City or town... Greencastle Pa  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No... 215 West Balls  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war...

## 3. (a) FULL NAME

WILLIAM E UPPERMAN

## 3. (b) Social Security Number

None

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married  
 6.(b) Name of husband or wife Viola upperman  
 6.(c) If alive, give age 76 years  
 7. Birth date of deceased (mo., day, yr.) Oct 6, 1873  
 8. AGE: Years 71 Months 7 Days 12  
 It less than one day hrs. min.

9. Birthplace Hamilton Twp Pa  
 (Town, county, and state)  
 10. Usual occupation Retired  
 11. Industry or business Farmer  
 12. Name Isaac upperman  
 13. Birthplace Hamilton Twp Pa  
 14. Maiden name Nancy Jane Turner  
 15. Birthplace Letterkenny Twp Pa

18. Informant Mollie Gardner  
 Address Greencastle Pa  
 17. (Burial, cremation or removal Which?) Date thereof May 21, 1945  
 (month) (day) (year)  
 Cemetery or crematory Cedar Hill  
 Location near Greencastle Pa  
 18. Funeral director G E Munnich  
 Address Greencastle Pa  
 19. May 19, 1945 Chas. Bowers  
 (Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 18, 1945 at 10:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 13, 1945 to May 18, 1945  
 and that I last saw him alive on May 17, 1945

Immediate cause of death: Atherosclerotic Cor. Vascular  
 renal disease

Due to...

Due to...

Other conditions: Bronchitis

(Include pregnancy within 3 months of death)

Major findings of operations...

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE: M. B. Bowers, M.D.

Address: Greencastle, Pa. Date signed: 5/18/45

RECEIVED

RECEIVED

RECEIVED  
MAY 22 1945  
BUREAU V.C.

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (B12)

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

### 1. PLACE OF DEATH:

County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

604 N. Mulberry Street

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Washington  
City or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)

Street No. 604 N. Mulberry Street

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3.(a) FULL NAME

Urilla Wakenight

### 3.(b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Widow

6.(b) Name of husband or wife Charles Wakenight

7. Birth date of deceased (mo., day, yr.)

May 13, 1865

6.(c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

79

11

23

hrs. min.

9. Birthplace Keedysville- Wash. Co., Md.

(Town, county, and state)

10. Usual occupation Home Duties

11. Industry or business

FATHER

12. Name

William Smith

13. Birthplace

Wash. Co., Md.

MOTHER

14. Maiden name

Mary

15. Birthplace

Wash. Co., Md.

18. Informant

Leonard Wakenight

Address

Hagerstown, Md.

17.

Burial

(Burial, cremation, or removal. Which?)

Date thereof

May 8, 1945  
(month) (day) (year)

Cemetery or crematory

Rose Hill Cemetery

Location

Hagerstown, Md.

18. Funeral director

Fred W. Kraiss

Address

Hagerstown, Md.

19.

May 8, 1945  
(Date rec'd by registrar)

19.

Chas H Powers  
Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH May 6, 1945 5:15 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 4, 1945 to May 6, 1945  
and that I last saw her alive on May 1, 1945

Immediate cause of death

Chronic cardio-vascular-renal disease

DURATION

3 years

Due to

Due to

Other conditions

None

(Include pregnancy within 3 months of death)

Major findings of operations

No operation

Date of op.

Autopsy results

No autopsy

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Ra Bee

M. D. or other

Address

Hagerstown, Md.

Date signed 5/7/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED  
MAY 10 1945  
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

## CERTIFICATE OF DEATH

Reg. Diat. No. 15394 302

## 1. PLACE OF DEATH:

County..... Washington  
 City or town..... Hagerstown  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:

Washington Co. Hospital

How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Washington

City or town..... Big Pool Rural  
 (If outside city or town limits, write RURAL and give nearest town)

Street No.....  
 (If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Victoria Warner

## 3. (b) Social Security Number

NONE

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Infant

6. (b) Name of husband or wife.....

6. (c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

May 10 1945

8. AGE:

Years

Months

Days

If less than one day

0003

hrs.

min.

9. Birthplace.....

Washington Co.

(Town, county, and state)

10. Usual occupation.....

11. Industry or business.....

FATHER

12. Name

James Warner

13. Birthplace

Frederick Co.

MOTHER

14. Maiden name

Bernice Mills

15. Birthplace

Washington Co.

16. Informant.....

James Warner

Address

Big Pool Rural17. Burial Date thereof..... May 11 1945

(Burial, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory

Park Head Cemetery

Location

Near Hancock, Md.

18. Funeral director.....

Snyder-Rowland

Address

Clearspring, Md.19. May 11 1945 Registrar

(Date rec'd by registrar)

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 10 19 45, at 6:45 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 10 1945 to May 10 1945and that I last saw him alive on May 10 1945

Immediate cause of death.....

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. ....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?).....

Means of injury.....

Injured at work?.....

23. SIGNATURE.....

M. D. or other

Address.....

Date signed 5/10/45

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

LOCAL HEALTH OFFICE OF MARYLAND

STATE OF MARYLAND

REC

MAY 14 1945

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County... WashingtonCity or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

744 West Washington St.

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... WashingtonCity or town... Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 744 West Washington St.  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3.(a) FULL NAME

Mary Alice Weaver

## 3.(b) Social Security Number

214-09-3850

4. Sex

Female

5. Color or race

white

6.(a) Single, married, widowed, or divorced

marriedB.(b) Name of husband or wife... Bruce T. Weaver6.(c) If alive, give age... 55 years

7. Birth date of

deceased (mo., day, yr.) February 7, 1894

8. AGE:

Years

Months

Days

If less than one day

51227

hrs.

min.

9. Birthplace Wingerton, Frank Co. Pa.

(Town, county, and state)

10. Usual occupation... sewing11. Industry or business HAG MFG Co12. Name... David Beaver13. Birthplace Wingerton, Pa14. Maiden name Ma. Gardenhour15. Birthplace Ringgold, Md.16. Informant Bruce T. WeaverAddress Hagerstown, Md17. Burial Date thereof... 5 6 45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... CemeteryLocation Smithsburg Md.18. Funeral director ANDREW K. COFFMANAddress HAGERSTOWN MD.19. Marys. 19 45 Charles Bowers  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH... May 4 19 45 at 2 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 1 19 44 to May 4 19 45and that I last saw him alive on May 4 19 45Immediate cause of death... Carcinoma of

DURATION

4 daysDue to Carcinoma of14 mosDue to CervixOther conditions metastasis to liver25 yrs

(Include pregnancy within 8 months of death)

Major findings of operations... L

Date of op. ....

Autopsy results...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

injured at work?

23. SIGNATURE... J. G. H. O. G. H. M. D. of deathAddress... Smithsburg Md. Date signed... 5/9/45

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

MAY 8 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 134

## CERTIFICATE OF DEATH

Dr. Brown 45396

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 7 Mos.

Hospital, institution, or street address where death occurred:

345 West Antietam StHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Hagerstown  
(If outside city or town limits, write RURAL and give nearest town)Street No. 345 West Antietam St

(If rural, give LOCATION)

None

2.(a) If veteran, name war

## 3. (a) FULL NAME

Mrs. Mary Margaret Wiley

## 3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife Jerre6. (c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) August 19 1869

8. AGE: Years Months Days If less than one day

7593hrs. min.9. Birthplace Mercersburg Franklin Co. Pa.  
(Town, county, and state)10. Usual occupation Housework11. Industry or business Own Home12. Name John A. Burrell13. Birthplace Mercersburg Pa.14. Maiden name Sylvia Byers15. Birthplace Mercersburg Pa.16. Informant Mrs. U.G. StoneAddress Hagerstown Md.17. Burial Date thereof 5/24/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Union Church CemeteryLocation Blairs Valley Pa.Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 24 1945 Charles H. Brown  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 22 1945 1945 at 9 A. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from April 10 1945 to May 21 1945and that I last saw him alive on May 21 1945Immediate cause of death Heart failureDue to TuberculosisDue to Pulmonary embolismOther conditions 5 yrs

(Include pregnancy within 3 months of death)

Major findings of operations NOAutopsy results NO

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: NOAccident, suicide, or homicide NO Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Wm. Charles BrownAddress 1644 W. Wash. Date signed 5-22-45

RECEIVED

MAY 25 1945

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

## CERTIFICATE OF DEATH

Reg. Dist. No. 302

<b>1. PLACE OF DEATH:</b> County... <u>Washington</u> City or town... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>62 years</u> Hospital, institution, or street address where death occurred: <u>Washington County Home</u> How long in hospital or institution? <u>5 years</u>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED:</b> (For newborn infants give residence of mother) State... <u>Md.</u> County... <u>Washington</u> City or town... <u>Hagerstown</u> (If outside city or town limits, write RURAL and give nearest town) Street No. .... (If rural, give LOCATION) 2.(a) If veteran, name war.....											
<b>3. (a) FULL NAME</b> <u>LeRoy Winters</u>				<b>3. (b) Social Security Number</b>											
<b>4. Sex</b> <u>male</u>		<b>5. Color or race</b> <u>white</u>		<b>6. (a) Single, married, widowed, or divorced</b> <u>married</u>											
<b>6. (b) Name of husband or wife</b> <u>Eva Winters</u>				<b>6. (c) If alive, give age</b> ..... years											
<b>7. Birth date of deceased (mo., day, yr.)</b> <u>January 13, 1883</u>				<b>8. AGE:</b> <table border="1"> <tr> <td>Years</td> <td>Months</td> <td>Days</td> <td>If less than one day</td> </tr> <tr> <td><u>62</u></td> <td><u>4</u></td> <td><u>2</u></td> <td><u>2</u> hrs. <u>0</u> min.</td> </tr> </table>				Years	Months	Days	If less than one day	<u>62</u>	<u>4</u>	<u>2</u>	<u>2</u> hrs. <u>0</u> min.
Years	Months	Days	If less than one day												
<u>62</u>	<u>4</u>	<u>2</u>	<u>2</u> hrs. <u>0</u> min.												
<b>9. Birthplace</b> <u>Hagerstown Washington Md.</u> (Town, county, and state)				<b>10. Usual occupation</b> <u>none</u>											
<b>11. Industry or business</b>				<b>12. Name</b> <u>Alvey Winters</u>											
<b>13. Birthplace</b> <u>Hagerstown, Md.</u>				<b>14. Maiden name</b> <u>Alice Huyett</u>											
<b>15. Birthplace</b> <u>Hagerstown, Md.</u>				<b>16. Informant</b> <u>Fred Long</u> Address <u>Hagerstown, Md.</u>											
<b>17. Burial</b> Date thereof <u>May 18, 1945</u> (Burial, cremation, or removal, Which?) (month) (day) (year) Cemetery or crematory <u>Washington County Home</u> <u>Hagerstown, Md.</u> Location				<b>18. Funeral director</b> <u>Scott F. Minnich &amp; Son</u> Address <u>Hagerstown, Md.</u>											
<b>19. Date rec'd by registrar</b> <u>May 18 1945</u>				<b>20. DATE OF DEATH</b> <u>May 15 1945</u> at <u>4:30A</u> M											
<b>21. I CERTIFY that death occurred on the date above stated; that I attended deceased from</b> <u>April 1945</u> to <u>May 15 1945</u> and that I last saw h. <u>live</u> on <u>May 8 1945</u> Immediate cause of death..... Due to..... Due to..... Other conditions..... (Include pregnancy within 3 months of death) Major findings of operations..... Date of op..... Autopsy results..... PHYSICIAN: Please underline the cause to which death should be charged statistically.															
<b>22. VIOLENCE: If death was due to external causes, fill in the following:</b> Accident, suicide, or homicide..... Date of..... Where did injury occur? (City or town) (County) (State) Injured at home, farm, industry, public place (where?) Means of injury Injured at work?															
<b>23. SIGNATURE</b> <u>Ernest H. [Signature]</u> M. D. or other Address <u>Hagerstown Md.</u> Date signed <u>5/16/45</u>															

19. Date rec'd by registrar May 18 1945 Registrar [Signature]

RECEIVED

MAY 21 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Dr. Ditto

05398

Reg. Dist. No. 302

## 1. PLACE OF DEATH:

County WashingtonCity or town Security  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 12 YearsHospital, institution, or street address where death occurred:  
Security RoadHow long in hospital or institution? None

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County WashingtonCity or town Security  
(If outside city or town limits, write RURAL and give nearest town)Street No. Security Road  
(If rural, give LOCATION)2.(a) If veteran, name war None

## 3. (a) FULL NAME

Mrs. Sadie Josephene Witzel

## 3. (b) Social Security Number

217-12-10794. Sex Male5. Color or race White6.(a) Single, married, widowed, or divorced Widow6.(b) Name of husband or wife Roy6.(c) If alive, give age - years7. Birth date of deceased (mo., day, yr.) December 18 18928. AGE: Years 52 Months 4 Days 23 If less than one day - hrs. - min.9. Birthplace Union Bridge Carroll Co Md.  
(Town, county, and state)10. Usual occupation Cook11. Industry or business Restaurant12. Name Edward Rogers13. Birthplace Union Bridge Md.14. Maiden name Mary Stine15. Birthplace Union Bridge Md.16. Informant Mrs James McManusAddress Security Md.17. Burial Burial Date thereof 5/14/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rose Hill CemeteryLocation Hagerstown Md.18. Funeral director Andrew K. CoffmanAddress Hagerstown Md.19. May 12 1945 Registrar W. H. Brown

(Date rec'd by registrar)

## MEDICAL CERTIFICATION

20. DATE OF DEATH May 11 1945 19 45, of 1 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from May 1 - 4 1945, to May 11 - 1945and that I last saw him alive on May 11 - 45 19 45Immediate cause of death Ch. MyocarditisDue to 6 moOther conditions -

(Include pregnancy within 3 months of death)

Major findings of operations -Date of op. -Autopsy results -

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide - Date of -

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) -Means of injury - Injured at work? -23. SIGNATURE W. H. Brown M. D. or other -Address Hagerstown Md. Date signed May 12 1945

RECEIVED  
MAY 15 1945  
BUREAU V.S.